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DRUG STORE NEWS®

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NEWS FOCUS

• Look for feathers to fly over a proposed new unit-of-use Rx packaging policy at APhA's annual meeting next month. Advocates say it will "minimize pharmacist involvement in the manipulative aspects of dispensing." Critics warn it will drive up both inventory costs and generic drug prices. APhA's recommendation praises the potential value of unit-of-use to "enhance pharmaceutical care," but opposes its exclusive use.

• Ortho and Virginia's Center for Innovative Technology (CIT) have reached a licensing agreement for continued development of a vaccine to stimulate women's immune systems to develop antibodies to sperm. CIT could be ready for human testing in two years. This birth control option could be administered by pill or injection, and its effect could last from two to five years.

• "Open your eyes before you open your mouth," says a new anti-tampering ad campaign cosponsored by the FDA and NDMA. Although not all product imperfections indicate tampering, the ads advise patients to be safe rather than sorry.

Loyalty is the prize in insulin market

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Costco blazes new trails to pharmacy

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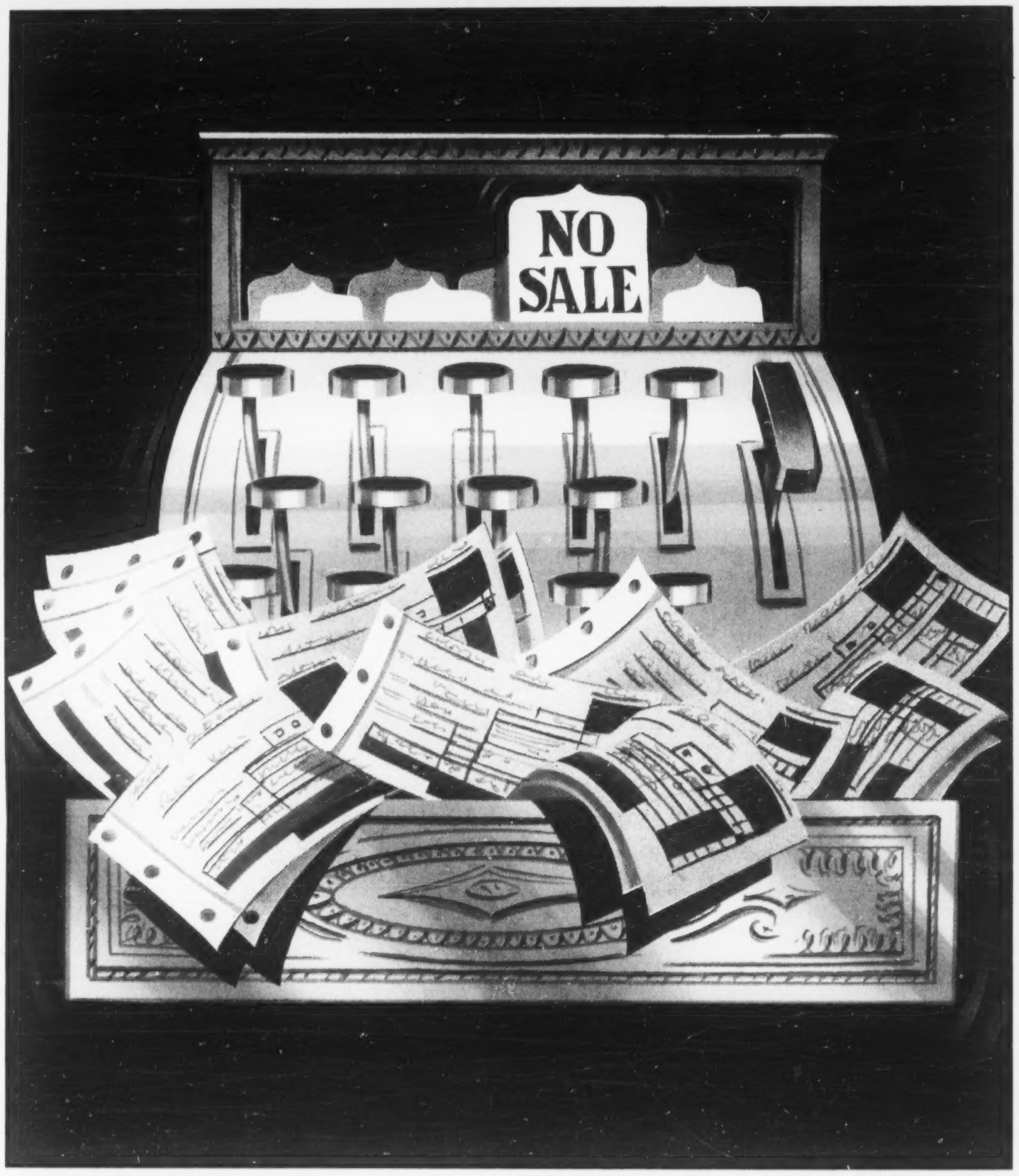

Employers seek to control spiraling Rx benefit costs

Third Party issues continue to plague pharmacists as cash in the till is replaced by paper promises of payment while gross margins erode. Also concerned about the third party explosion are those who pay for drug benefits: the employers. Drug Store News *talks to third party administrators about how employers are gearing up to control costs, and what role pharmacists play in helping them manage the pharmaceutical benefit, beginning on page 17.*

for the PHARMACIST

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FEATURES

Cover: Third party growth plagues pharmacy and payors

Employers, faced with rising prescription costs, look to ease their financial burden through pharmaceutical benefits management. Contracting segments of the business to third party administrators is one of the strategies they're using. Does this mean more headaches for drug stores? *Page 17*

Brand loyalty drives insulin buys

Wrestle as they might to gain market share, manufacturers are still finding it a hard struggle to convince diabetes patients to switch insulin products. Retailers say physician's recommendations carry the most weight. *Page 27*

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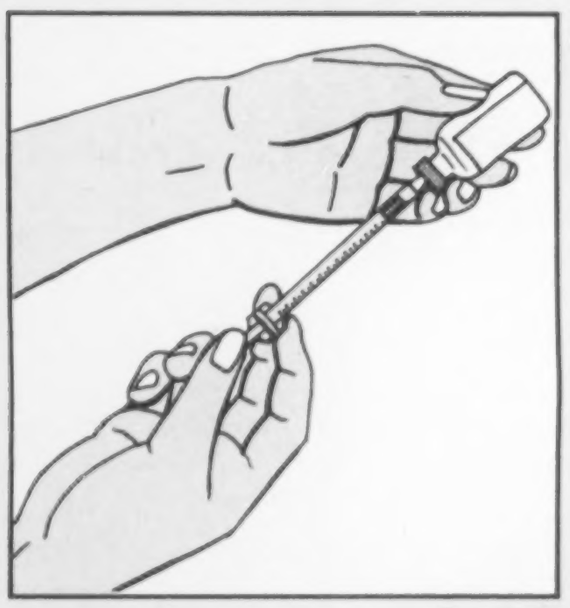
Demographics are competitive tool

You don't have to have an MBA to plan a marketing strategy. Demographics—inexpensive and easy to get—can help retailers evaluate their markets, plan for expansion and create an image. *Page 30*



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Pharmacy joins the Costco club

Costco, the third largest wholesale club, reports its stores are filling 400 to 500 prescriptions a day. The departments require a higher service level than the club is used to providing, but the strong and lucrative customer pull is worth it. *Page 33*

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FDA is slower making NDAs than a decade ago

Last year the FDA approved 30 totally new drugs — seven more than the year before and the most since 1985 when the agency also cleared 30 "new molecular entities" (NMEs).

Five of the NMEs approved in 1991 are products that FDA'ers believe will offer a "significant therapeutic gain" over existing medications.

In addition to the NMEs, FDA issued 33 new drug approvals (NDAs) for products representing variations on existing drugs (new dosage forms, combinations), approved 188 new generics, and issued 76 biologics licenses.

But while the FDA's drug approval productivity showed some signs of improving last year, the figures reveal some discouraging news as well.

On the downside, the average FDA review time needed to clear the 30 NMEs approved in 1991 increased to 30.3 months — 2.6 months longer than the year before.

According to industry sources, last year's apparent slowdown in FDA new drug reviews may be a phantom blip on the statistical radar screen.

Indeed, Gerald Mossinghoff, PMA president, said that "the average approval time was increased considerably by the FDA's efforts to reduce the backlog of long-pending new drug applications (NDAs)."

Critics of the agency, howev-

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'New Molecular Entities' Approved in 1991

Drug	Manufacturer approval	Indication	Rating*	Review Time (months)	Prior Foreign
Accupril (quinapril HCl)	Warner-Lambert	hypertension	1C	31.1	Yes
Altace (ramipril)	Hoechst-Roussel	hypertension	1C	26.7	Yes
Aredia (pamidronate disodium)	Ciba-Geigy	hypercalcemia in cancer patients	1B-E	22.3	No
Biaxin (clarithromycin)	Abbott	anti-infective	1B	19.3	Yes
Cefzil (cefprozil)	Bristol-Myers Squibb	anti-infective	1C	20.8	No
Ceredase (alglucerase)	Genzyme	Gaucher's disease	1A-VE	11.4	No
Chemet (succimer)	McNeil	juvenile lead poisoning	1B-V	17.3	Yes
Fludara (fludarabine phosphate)	Berlex	chronic lymphocytic leukemia	1A-VE	22.0	No
Foscavir (foscarnet sodium)	Astra	AIDS-related CMV retinitis	1B-AAE	12.2	Yes
Ganite (gallium nitrate)	Fujisawa	cancer-related hypercalcemia	1B-VE	22.0	No
ISMO (isosorbide mononitrate)	Wyeth-Ayerst	angina-pectoris prevention	1C	96.1	Yes
Lodine (etodolac)	Wyeth-Ayerst	anti-arthritic	1C	97.1	Yes
Lorabid (loracarbef)	Lilly	anti-infective	1C	16.1	No
Lotensin (benazepril HCl)	Ciba-Geigy	hypertension	1C	35.6	Yes
Mazicon (flumazenil)	Hoffmann-LaRoche	benzodiazepine reversal	1B	12.3	Yes
Monopril (fosinopril sodium)	Bristol-Myers Squibb	hypertension	1C	30.0	Yes
Nipent (pentostatin)	Warner-Lambert	hairy cell leukemia	1A-VE	8.0	No
Nuromax (doxacurium chloride)	Burroughs Wellcome	muscle relaxant	1C	23.5	No
Penetrex (enoxacin)	Warner-Lambert	anti-infective	1C	62.3	Yes
Plendil (felodipine)	Merck	hypertension	1C	17.3	Yes
Pravachol (pravastatin sodium)	Bristol-Myers Squibb	cholesterol reduction	1C	33.0	Yes
Relafen (nabumetone)	SmithKline Beecham	anti-arthritic	1C	70.5	Yes
Supprelin (histrelin acetate)	Ortho	precocious puberty	1A-V	31.1	No
Survanta (beractant)	Abbott	infantile respiratory distress syndrome	1C-VE	17.9	Yes
Ticlid (ticlopidine HCl)	Syntex	thrombotic stroke prevention	1B-E	23.5	Yes
Videx (didanosine)	Bristol-Myers Squibb	AIDS	1A-AAE	6.2	No
Zithromax (azithromycin)	Pfizer	anti-infective	1B	18.7	No
Zocor (simvastatin)	Merck	cholesterol reduction	1C	50.3	Yes
Zofran (ondansetron HCl)	Glaxo	anti-nausea in cancer patients	1B	14.8	Yes
Zoloft (sertraline)	Pfizer	anti-depressant	1C	44.6	No

*RATING CODE:
1 — drug that is a new molecular entity
A — drug offering "significant therapeutic gain" B — drug offering "moderate therapeutic gain" C — drug offering "little or no therapeutic gain"
AA — highest priority classification for AIDS drugs E — drug for severely debilitating or life threatening illness V — orphan drug

Source: U.S. Food and Drug Administration; Pharmaceutical Manufacturers Association.

FDA is slower making NDAs than it did in the early '80s

Continued from page 11

er, counter that the drug approval backlog reflects decades of FDA mismanagement and should not be cited as an excuse for slow-footed review procedures today. By law, the FDA is required to complete NDA reviews in six months, but the agency was unable to process a single new drug within that statutory period last year.

Even more disturbing to many, however, is the persistent evidence of a "drug lag" which may be slowing the availabity of new medicines to patients in this country.

Over half the new drugs approved for U.S. marketing last year had already been available to patients in Europe, Japan and other countries. Among the NMEs approved in '91:

- Accupril (quinapril HCl), an antihypertensive from Warner-Lambert prescribed since 1989 for patients in France, Italy, South Africa and three dozen other countries;
- Wyeth-Ayerst's ISMO (isosorbide mononitrate), marketed in Germany and dozens of other countries since the early 1980s, yet required more than eight years of FDA review;
- Chemet (succimer), an orphan drug adopted by McNeil, has been used as a treatment for juvenile lead poisoning in China since the mid-1960s;
- Glaxo's Zofran (ondansetron HCl), a drug for relief from chemotherapy-related nausea, was made available to cancer patients in 47 countries before FDA's approval for U.S. marketing on the last day of 1991.

FDA: is it padding drug approval 'body count'?

Although the Food and Drug Administration granted final marketing approval to 30 new molecular entities during 1991, there are indications that a number of those NMEs were rushed through at the eleventh hour to avoid the appearance of an FDA slowdown.

Nearly one-third of last year's new drug crop—nine of the 30 NMEs cleared for marketing in '91—were approved during the final two weeks of the year.

Several, including Warner-Lambert's Penetrex (an anti-infective which has been under review at the FDA for 62 months), were not approved until the final day of 1991.

Although FDA officials deny "cutting any corners" to inflate the NME count during Commissioner David Kessler's first year in office, it's obvious that federal drug reviewers were straining to clear as many new drugs as possible before the end of '91.

Without the nine NMEs rushed through during the final two weeks of the year, the 1991 new drug approval harvest would have been the second smallest of the past decade—a major embarrassment for an FDA's gung ho new commissioner.

Rx R&D may be yielding diminishing returns

The pharmaceutical industry's "investment" in new drug research and development rose 14 percent last year to $9.6 billion—an increase that is just about on pace with the growth of drug R&D since the early 1970s.

PMA staffers point out that dollars spent by their members on R&D have been doubling every five years for the past two decades. That, they maintain, is a sign of the industry's commitment to bringing new medical therapies to the market.

But, based on the sheer numbers of totally new drugs resulting from that ever-growing research investment, it is also an indication that pharmaceutical industry R&D is delivering less and less bang for the buck.

In 1982, for example, PMA's member firms laid out just under $3 billion for research and development, an average of about $100 million for each of the 28 NMEs approved for marketing that year.

By '87, the industry's worldwide R&D costs had climbed to $5.5 billion—$262 million for each new drug approved that year. Last year's $9.6 billion R&D spending averages out to $320 million per NME approved.

Of course, not all industry R&D spending goes to develop NMEs. Much of it is earmarked for new versions of existing drugs, while a good deal of it goes into "dry holes" that yield no marketable products.

But the point is clear: although pharmaceutical industry R&D spending is doubling every five years, this increased investment isn't generating any more NMEs than in the past.

That's one reason why drug stores, consumers and taxpayers are paying sharply higher prices for the new drugs that are coming out of the pipeline today.

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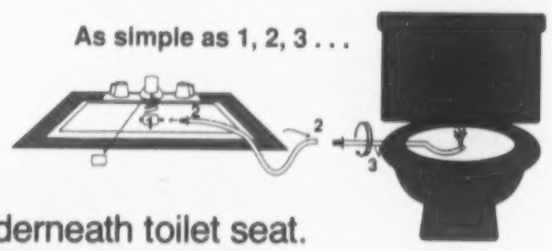

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Employers try to dampen 3rd party benefit costs

By Dianne Tharp, R.Ph.

The third party card programs so visible at the retail pharmacy level are but the tip of the iceberg of total employer-provided pharmacy benefits. While pharmacies see over 40 percent of their business dispensed on third-party cards, 75 percent of the employer-provided pharmacy benefit is through indemnity or major medical plans.

The U.S. Department of Commerce reports 40 percent of today's drug market belongs to third party and predicts a whopping 60 percent share by 1995. And with an escalating proportion of health care costs going to pharmaceuticals (11 percent), the spotlight in employer-provided health care coverage is on drug benefits.

Employee drug benefits are increasing dramatically as both the cost and number of prescriptions rise. Fueling the trend is the shift of patients from hospitals to ambulatory care centers. What's more, manufacturers have been developing and promoting newer, often expensive chronic care medicines to go along with the consumer trend to more healthy lifestyles and improved quality of life. Better drug compliance contributes to this improvement. Besides benefits for active employees, employers also face increasing costs for retirees. Recent studies have shown that as much as 30 percent to 40 percent of employers' retiree health care costs are for drug benefits alone. And these retirees are living longer because of medical care advances.

Thus, the catch words of the '90s has become pharmacy benefits management, or, how do you keep the bonfire from raging out of control?

One solution: Employers are giving more of the pharmacy portion of their health plans to third party administrators (TPAs), and letting them handle the problem entirely.

The challenge to TPAs, according to Ben Zelman, senior vp of strategic planning of InsuRx, a prescription benefit management company based in Cleveland, is to respond to differing benefit design requirements of plan sponsors while maximizing cost control.

Have PSAOs failed?

In selecting cost-effective pharmacy providers, some TPAs report more success with chain pharmacies than with groups representing independents, such as Pharmacy Services Administration Organizations (PSAOs).

Chains stand to benefit from this trend toward TPAs, says Elan Rubinstein of Rubinstein Associates, a prescription benefits consultant to employers.

"PSAOs have not worked out too well, competitively speaking," Rubinstein says. The reason: independents have to check first with their PSAO network before contracting to participate as a pharmacy provider. It's hard to get all parties to agree. Dealing with one individual at a drug chain is easier, Rubinstein claims. "Like one-stop shopping, dealing with chains has been a lot more convenient — and they've become pretty sophisticated," he says.

Larry Pahigian, senior vp and national sales manager, Prescription Health Services (PHS), a prescription benefit administrator and claims processor, agrees with Rubinstein on PSAOs. "Five years ago, I would have said that PSAOs are a beautiful thing. Today, they are non-active, and will not be a meaningful force on the health care industry," says Pahigian.

Zelman of InsuRx supports the fact that PSAOs "didn't negotiate" to participate as pharmacy providers and "too many parties" are involved in the process. This doesn't mean that independent pharmacies are overlooked by this TPA.

InsuRx has successfully negotiated with independent pharmacies directly. "Independents are an important part of our pharmaceutical benefit delivery system," Zelman says. That may account, in part, for InsuRx' explosive 5,000 percent growth over the last five years, from $109,000 in their first year of business to $5.6 million in 1990.

John Rector, vp government affairs NARD, blames manufacturers for PSAOs' lack of success in negotiating third-party business. Multi-tier pricing issues aside, Rector states that "if PSAOs had access to normal economies of scale, they would have been successful." He says he is not aware of a single company that will deal with independents' buying groups.

Not to sell PSAOs short, he adds, "just the idea that there are mechanisms or vehicles to allow independents to participate" gives PSAOs value.

Advent of POS technology

To date, pharmacy benefit management has not been easy, but POS technology is revolutionizing third party.

POS puts eligibility information and benefits design on the pharmacy counter. With access to profiles, the POS vendor or pharmacy benefits manager can determine if patients are eligible, if they have satisfied their deductible, if the drugs are covered, and what the copays should be. And POS gives the payor, via the TPA, new power to manage drug benefits.

In spite of the power of POS, one big problem with managed care today, according to InsuRx' Zelman, is fragmentation. Today, each health care component is independent of the others. "Ultimately, benefits will be coordinated and data will be merged. Only then can we really manage the person's care," says Zelman.

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Employers' 3rd party benefit

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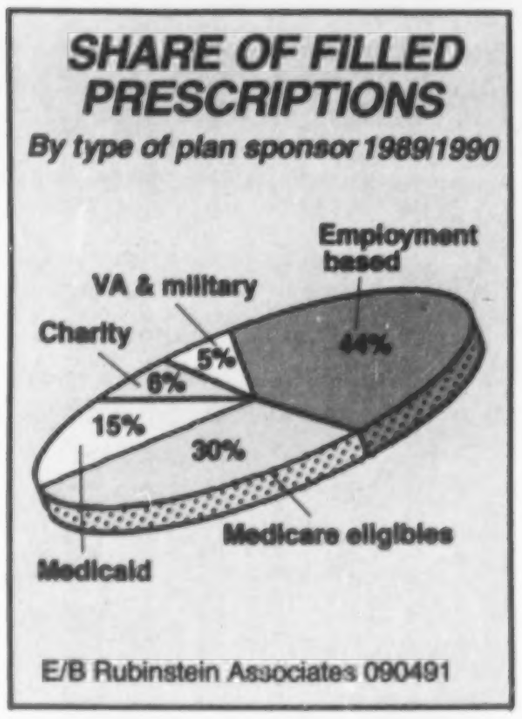
Rubinstein feels that there is a movement away from what he calls "cash/carry/ reimburse" — indemnity or major medical plans — where the patient submits the bill for reimbursement. He sees Paid's new Claim Direct product and others like it as transitional solutions. (Claim Direct is an indemnity plan whereby claims are sent via POS so the employer can collect data and do DUR. But the customer must pay cash at the pharmacy and submit a paper claim for reimbursement.

Pharmacists have objected to this type of program because they must pay a POS transaction charge yet complete a paper claim form. In some cases, they have to accept the plan sponsor's version of usual and customary retail, which may be less than what the pharmacist is charging the more elusive cash customer.

Part of the employer appeal for employee self-reimbursement is the fact that initial out-of-pocket expenditure by the employee may cause more judicious utilization. Add to that anticipated savings from the "shoe box" effect, where the employee puts the receipt in a shoe box and forgets to submit it for reimbursement.

Elan doesn't see this as the answer to escalating drug costs, however, because it is inconvenient for the employee and more expensive for the employer to administer. A more effective long-term solution would involve several possibilities: shifting costs to employees by increasing co-payments; going to co-insurance or a percentage co-pay; increasing deductibles; and returning to usual and customary retail when a maximum drug benefit is reached. "The trick is to figure out ways to help control costs without affecting levels of service," says Bill Turner, sales manager for prescription claims processor, Argus Health Systems.

PHS' Pahigian disagrees with Rubinstein's assessment of the future of the POS/indemnity product. He says putting an indemnity program online is an attempt to combine the best components of both plans, and "makes this program more workable." He sees programs like Claim Direct as another way of cost-sharing, and predicts attempts to control costs in this way will increase.



Health care faces crucial debate

The future will see third party coverage in pharmacies increasing as employers switch from indemnity programs to managed pharmacy programs. And, with over 34 million citizens without health insurance, can nationalized health care be far behind?

In the 1992 election year, health care will be a key debated issue. The "pay or play" proposal seeks to make employers pay into a federal pool, and the government will cover beneficiaries, or the employer must offer benefits themselves. Employers that do not "play" may push government mandates.

Future of service

Is there a future for clinical services? Rubinstein feels the jury is still out. There is no hard evidence to date documenting what employers are saving through pharmacist clinical intervention. Most pharmacy benefit management companies have the technology now and are doing clinical interventions, including concurrent and retrospective DUR. So what is the pharmacist doing?

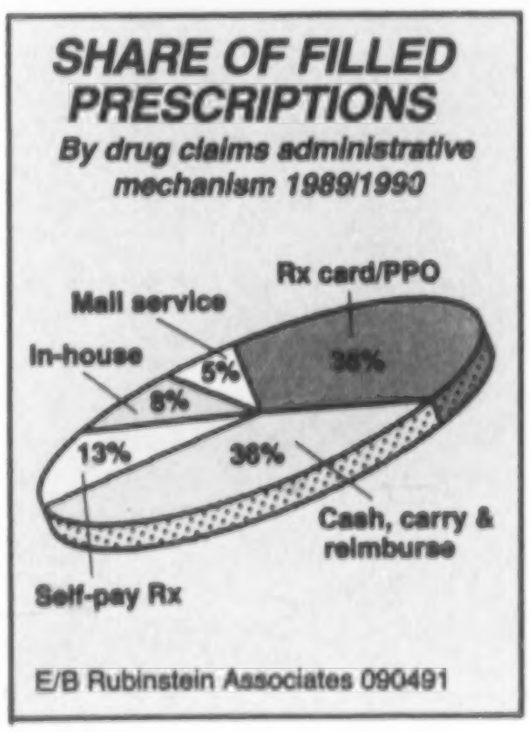
Many employers see the pharmacist's role as passive, says Rubinstein. Do they just key in the data? If so, why pay more for pharmacist services when the TPA will do the review?

"Managed care is a double edged sword that can work for or against pharmacy," says Rubinstein, "unless roles are found for pharmacists in the outpatient setting similar to those in the inpatient setting" and the value of those roles is documented.

A major push for more clinical intervention will result next January when OBRA '90 will require DUR for Medicaid patients.

Who will benefit? "Not necessarily pharmacy, but the people in the middle like pharmacy benefits managers, TPAs and claims processors," says Rubinstein. "This could be an important loss for pharmacy."

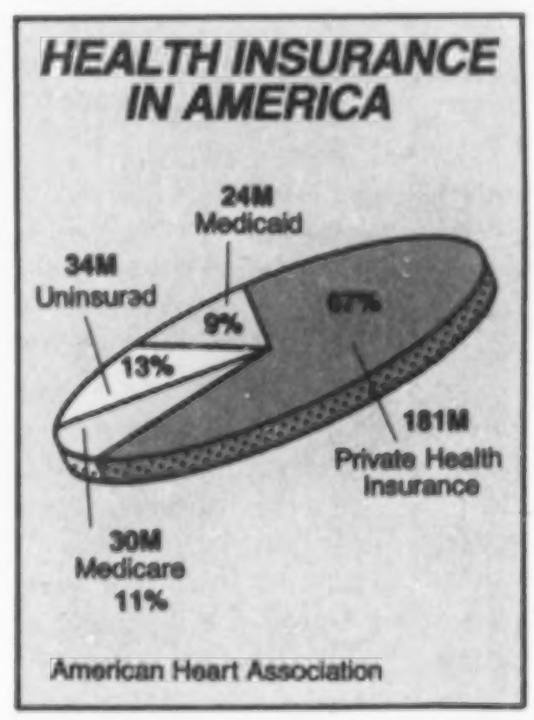
Yet both Pahigian and Mark Wermes, regional vp of sales at PHS, believe that "the pharmacist plays a major role in benefits management." This role includes "decreasing excessive prescribing and using professional judgment in the delivery of quality drugs at good costs," says Pahigian. Wermes sums it up when he says, "All health care is a local phenomenon. It comes down to the pharmacist to provide that health care." They see their role—the role of the TPA—as "taking a lead in determining compliance from retrospective review, and forecasting the best changes going forward."



Future of MOPS questioned by employers

Although future predictions are anyone's best guess, Rubinstein sees mail order pharmacy service (MOPS) slowing down in the next few years. "Before, [MOPS] was easy to implement and employers were sold on savings," says Rubinstein. Given the cost containment opportunities with POS and pharmacy benefits management, there may be less to be saved with MOPS.

InsuRx' Zelman agrees that more employers are questioning the value of MOPS, since it hasn't been shown to save them money. The real change in the pharmacy benefits business will be at the retail level, according to Rubinstein, "and pharmacy needs to get very aggressive in this area."



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Jon C. Wagner, Pharm.D., Assistant Dean, Student and Professional Affairs, Assistant Professor of Pharmacy Practice, College of Pharmacy, University of Nebraska Medical Center, Omaha, Nebraska.

Goal:

1. Review the history and epidemiology of drug use in athletics.
2. Describe the unique environment and stresses of athletics which may put an athlete at risk for substance abuse.
3. Discuss the potential performance-enhancing properties of a variety of drugs.
4. Review current attempts in amateur and professional athletics to control drug use.
5. Provide examples and suggestions for how pharmacists can apply their knowledge in the area of sports pharmacy.

Objectives:

After completion of this lesson, the pharmacist should be able to:
1. recognize the past and present incidence of drug use by athletes.
2. identify stresses and pressures which may put the athlete at risk for substance abuse.
3. recognize the drugs athletes may use to enhance their performance and the rationale for their use.
4. differentiate between the attempts of amateur and professional sports organizations to control drug use.
5. recognize opportunities for pharmacists to apply their unique knowledge in the area of sports pharmacy.

How widespread is the use of drugs in athletics?

Introduction

In the premier event of all of sports, Ben Johnson decisively won the 100 meter dash at the 1988 Summer Olympic Games in Seoul. Seen by millions worldwide, a muscular Johnson defeated seemingly easily his arch rival, Carl Lewis. Just days later, his triumph turned into tragedy as he was stripped of the gold medal due to a urine drug test which was positive for the anabolic steroid, stanazolol.

Never before had the use of drugs in athletics received such attention. Not even when athletes died from their drug use. This single event produced discussions ranging from pharmacology to ethics, with most of the attention focused on the elite athlete.

These debates have raised a number of questions: How widespread is the use of drugs in athletics? Is there a problem with social drugs of abuse as well as performance-enhancing drugs? Do performance-enhancing drugs really work? How dangerous are these drugs? What can be done to control the use of drugs in athletics? Pharmacists with their knowledge of drugs, professional commitment to rationale drug use, and accessibility to the public, are in a unique position to help answer these questions.

History of sports drug use

From the beginning of athletic competition, participants have looked for ways to improve performance. This has led to advances in techniques, training methods and nutrition.

Unfortunately, it has also led to experimentation with a variety of drugs. Despite the just recent attention, the problem of drug use in athletics can be traced back to the ancient Greek Olympics, where competitors took herbs and mushrooms to improve their performance. In the 19th century, endurance athletes in Europe often consumed either sugar cubes dipped in nitroglycerin, or a drink known as *vin mariani*, which was a mixture of coca leaves and wine. Both of these concoctions reportedly reduced fatigue.

In the more modern era of sports, athletes began using more potent drugs. During the 1950s, Soviet and American athletes began using anabolic steroids and amphetamines. In 1968, the International Olympic Committee began conducting urine drug testing at sanctioned events, but few

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athletes were ever caught using banned drugs.

By the 1980s, drug assay technology had advanced to where even small amounts of drugs and their metabolites could be detected. That decade brought public awareness that athletes could not escape the consequences of social drug abuse. Alcohol and cocaine were the most common drugs of abuse. Alcohol claimed the life of professional hockey player, Pelle Lindbergh, through an alcohol-related automobile accident. In 1986, Len Bias, a standout collegiate basketball player, and Don Rogers, a professional football player, died from cocaine overdose. These cases represent only a few of the hundreds which involve athletes and substance abuse.

Most recently, anabolic steroids have returned to the sports pages with Lyle Alzado's claim that his past steroid use has caused his inoperable brain cancer; the suicide attempt by Terry Long, of the Pittsburgh Steelers, a known steroid user; and the disclosure of widespread, sophisticated and controlled use of steroids by East German athletes. All of this attention on drug use in athletics has resulted in an increased public awareness and concern.

Exploring the problem

The public's concern over this problem is often articulated through some basic questions, the first being "Is this a widespread problem, or is it limited to elite athletes?"

Only a few epidemiologic studies exist which have looked exclusively at substance abuse among athletes. One of the earliest was conducted in 1985, with a follow-up in 1989, by the College of Human Medicine at Michigan State University at the request of the National Collegiate Athletic Association. This study examined performance-enhancing and social drug use among a cross-section of collegiate athletes.

Table 1 shows the substance abuse patterns in college student athletes from the 1985 and 1989 studies. The findings suggest that a substantial number of college athletes use or have used drugs, with alcohol the clear social drug of choice. The data also show that the majority of all substance abuse begins while the athletes are in junior or senior high school. Over 70 percent of alcohol, marijuana, and cocaine users began social drug use before entering college. Nearly one quarter of anabolic steroid users admitted to taking them prior to entering college.

These results demonstrate that the problem is not one that occurs once athletes reach an elite level, but one that can be traced back to adolescence. Anabolic steroid use has been studied to some extent in this population. The largest, most frequently quoted survey was conducted in 1988. This study suggests that as many as 250,000 to 500,000 anabolic steroid users are adolescents.

Reasons for drug abuse

But why do athletes take drugs? Drug use by athletes can be divided into four categories: 1) therapeutic; 2) social; 3) performance-enhancing; and 4) the use of drugs to mask the presence of other drugs in the urine.

Many drugs can fall into more than one category, and in fact, may be classified differently by different sports organizations. For example, a bronchodilator may be considered a therapeutic drug when used to treat an asthmatic athlete, yet when used by a non-asthmatic, the drug could enhance performance.

Athletes often need medical care for illness and injury and many times, this necessitates the legitimate use of drugs. Because of the aforementioned overlap between categories, drug products must be carefully selected for athletes competing in events where urine drug testing is conducted.

There have been cases where athletes were disqualified because they took a cold remedy which contained a drug which was banned from competition, most frequently, phenylpropanolamine. Athletes are not immune from the pressures and temptations to use social drugs of abuse.

The elite and professional athlete's lifestyle of high income, frequent travel, considerable idle time and macho image have been cited as possible risk factors. Athletes at all levels, even those in junior high, are visible to criticism and have a consistent expectation to improve. In addition, most athletic careers don't end when an athlete reaches his 30s, but instead, in junior and senior high school. These factors, plus the seemingly clear connection between sports and alcohol, may increase the use of social drugs in athletes as a coping behavior.

One way to respond to the pressures of being an athlete is to look for a way to improve performance. When training and nutrition techniques no longer provide the expected results, some athletes find themselves contemplating performance-enhancing drugs. The term "ergogenic" is often used to describe these drugs.

Ergogenic means the use of drugs or physiologic substances taken in an abnormal manner with the sole intent to artificially improve athletic performance. This definition uses the phrase "physiologic substances" in addition to drugs so as to include the use of naturally occurring products such as testosterone, and to include *blood doping*.

Blood doping is a procedure where a portion of an endurance athlete's blood is removed and stored during training. The red blood cells are then separated and transfused back into the athlete prior to competition. The goal is to increase red blood cell mass to improve oxygen consumption during the athletic event.

With the increased use of urine drug testing at athletic events, athletes have begun looking for ways to avoid detection. The lengths some athletes may go to avoid getting caught is demonstrated in the often reported story where an athlete was found having "clean" urine instilled into his bladder before a drug test. A less invasive way to avoid detection is to use drugs to mask the presence of other drugs in the urine. Diuretics are used to try to reduce the concentration of other drugs in the urine by increasing the rate of excretion. Probenecid, which is known to delay elimination of penicillin, has been used to similarly block excretion of anabolic steroids.

Table 1

Substance abuse patterns in college student athletes

	1985	1989
Number of athletes surveyed	2049	2282
Ergogenic drug use in previous year		
Amphetamines	8%	3
Anabolic steroids	4	5
Barbiturates	2	2
Major analgesics	28	34
Weight loss products	n/a	5
Social drug use in previous year		
Alcohol	88	89
Caffeine	68	64
Cocaine/crack	17	5
Psychedelics	4	4
Marijuana	36	28
Smokeless tobacco	20	28

Performance drugs: A to Z

Success in athletics is the result of many factors: skill level, the opponent's skill level, playing conditions and mental attitude, just to name a few. Drugs can't improve on these factors, but they can potentially improve size, strength, speed and endurance in some individuals. Meaningful changes in these physiologic components could impact athletic performance.

Continued on page 39

Continued from page 38

Alcohol. Ethyl alcohol is one of the most used and abused drugs among athletes and in society in general. A common misconception is that beer and other alcohol-containing beverages are ergogenic since they are rich in carbohydrates, vitamins and minerals. On the contrary, alcohol is not a very good source of these nutrients and appears to be devoid of any ergogenic properties. Also, even modest social use of the drug may adversely effect performance. Decision-making, which is important in many sports, can be impacted even after the blood alcohol levels have returned to zero and no physical effects are evident.

This latent effect was first studied in Navy aircraft pilots in a controlled environment. The pilots flew a mission in a flight simulator. The response to an emergency situation was objectively measured.

At a later date, the same pilots were given enough alcohol to produce a blood alcohol level of 100mg/dl. Fourteen hours later the pilots flew an equally demanding, yet different flight simulation. Even though blood alcohol levels were zero and none of the pilots reported any ill effects from the previous night's "cocktail party," the simulator scores were significantly worse.

This latent effect, which has not been studied in athletes, could produce similar results in decision-making, visual tracking and information processing. Similar effects may also be seen on physiologic variables such as strength and endurance.

One area of athletic endeavor which can be positively influenced by alcohol is in precision events, such as pistol marksmanship and archery. In these events, alcohol can improve performance by reducing hand tremor. Because of this, alcohol is banned at these type of events by the IOC and NCAA.

Amphetamines. The first performance studies of amphetamines were for military applications rather than athletics. During World War II, experiments showed that soldiers could march longer distances and ignore pain.

A recent study looked at the effects of amphetamines on athletic performance. The investigators measured individual components associated with athletic performance in six subjects. The physiologic components measured were strength, muscular power, sprinting speed, acceleration, aerobic power and anaerobic capacity.

While under the influence of amphetamines, the subjects showed improvements in all of the components except sprinting speed. Significant improvements were noted in strength, acceleration and anaerobic capacity. Slight increases were observed in time-to-exhaustion and heart rate. Even though time-to-exhaustion was improved, lactic acid concentrations and maximum volume of oxygen (VO_2Max) remained unchanged.

This evidence suggests that amphetamines do not delay exhaustion as once thought, but instead masks the body's response to exhaustion. This certainly could explain the deaths of elite endurance athletes in the 1960s while taking amphetamines. The athletes essentially ran or cycled themselves to death because they were unaware of their fatigue.

Anabolic steroids. Anabolic steroids are synthetic derivatives of the male sex hormone testosterone. They were developed to try to produce a compound which was purely anabolic, or tissue-building, and free of any androgenic, or masculinizing effects. Since no compound has yet to be developed which is *only* anabolic, these drugs should technically be referred to as anabolic-androgenic steroids.

The claim made by those athletes who use anabolic steroids is that the drugs can increase lean body mass, strength and aggressiveness as well as reduce recovery time between workouts. These claims were initially refuted by the medical profession, based on a few studies using therapeutic doses of anabolic steroids.

In 1984, a review of the literature was conducted which concluded that anabolic steroids could increase size and strength if several conditions were met. First, intense weight training must accompany steroid use. Second, the athlete must consume a high protein, high caloric diet. Finally, any changes in strength must be measured by single-repetition, maximum weight techniques familiar to the athlete.

How these drugs work is still not completely understood. A number of possible mechanisms have been suggested. The first involves anabolic steroid receptors which have been located in muscle cells. When occupied by steroids, these receptors stimulate the production of RNA, which in turn increases protein synthesis. The second possible mechanism is that these drugs produce a positive nitrogen balance which increases the amount of protein available for tissue building. The final theory suggests that anabolic steroids produce euphoria and a sense of reduced fatigue which allows the athlete to train longer and harder.

The one area where performance research appears unequivocal is the **absence of effect on endurance**. Anabolic steroids don't improve aerobic metabolism or VO_2Max. But, they have the potential to produce a variety of adverse effects in athletes. Most of what is known about these drugs' toxicity comes from diseased patients receiving therapeutic doses.

Athletes who take anabolic steroids often take doses 10 to 100 times the therapeutic dose. The regimens may include more than one steroid preparation, a practice known as "stacking." This combination is taken for anywhere from 4 to 18 weeks and followed by a drug-free period of approximately the same length. This pattern is referred to as "cycling," and is timed in such a way that the athlete will be drug-free during any competition where drug testing is conducted. When the anabolic regimen no longer produces the desired gains in mass and strength, which the athlete's call "plateauing," the number of drugs or doses or both are increased.

These patterns of anabolic steroid use clearly demonstrate that 1) athletes will consume massive doses in their quest to be bigger and stronger; and 2) they are aware of the toxicity of these agents. Whether these drug-free cycles and the relative young age of the athletes offset the toxicity is not known.

Continued on page 40

ANSWER SECTION

***Drug Store News for the Pharmacist* is approved by the American Council on Pharmaceutical Education as a provider of continuing pharmaceutical education.**

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The adverse reactions associated with anabolic steroids range from minor to severe, and effect virtually every body system. Anabolic steroids frequently involve the liver, resulting in peliosis hepatis, hepatic tumors, cholestasis and non-specific elevations in liver function tests.

Peliosis hepatis is a condition where blood-filled sacs are formed in the liver which can rupture and cause severe hemorrhaging.

Liver tumors have been reported in the general population receiving anabolic steroids for medical conditions as well as in athletes. Elevations can be seen in athletes taking steroids, but also is seen in athletes undergoing strenuous physical training. This type of training can raise liver enzymes which are also found in muscle tissue. For that reason, anabolic steroid use should be monitored by watching alkaline phosphatase and the liver-specific iso-enzyme of lactate dehydrogenase.

Anabolic steroids affect the endocrine system in both men and women. In males, circulating testosterone is reduced which results in decreased sperm production and testicular size. The effect on sex drive is variable, but often is enhanced early in the course of steroid use, and then decreases to normal or below normal with continued use. Human chorionic gonadotropin is used by some anabolic steroid users in an attempt to reverse the effects on testicular size and sex drive. Males may also experience gynecomastia, especially with the use of high doses of anabolic steroids. This condition of increased breast tissue develops when excess androgen is converted to estrogen. Some anabolic steroid users take tamoxifen, an antiestrogen used to treat breast cancer, to reverse the gynecomastia. Breast tissue usually returns to normal once anabolic steroid use is stopped.

In females, the use of anabolic steroids results in masculinizing characteristics. Deepening of the voice, male-patterned baldness, decreased breast size and enlarged clitoris have all been reported. Many of these masculinizing effects are not reversible even with discontinuation of anabolic steroid use.

The cardiovascular system can also be adversely effected by anabolic steroids. These drugs can cause significant decreases in high density lipoprotein (HDL) and increases in low density lipoprotein (LDL). This altered HDL/LDL ratio is a known risk factor for cardiovascular disease. Lipid levels will return to baseline once anabolic steroids are discontinued. Other cardiac complications reported among anabolic steroid users include hypertension, cardiac enlargement and stroke.

An emerging body of evidence suggests that anabolic steroids can result in serious psychiatric problems. A survey of 41 known steroid users revealed that 22 percent met the criteria for a manic episode while on steroids, or for a depressive episode while off the drugs. Case reports describe a number of other psychiatric symptoms including euphoria, irritability, hyperactivity, delusions, acute schizophrenia, increased aggressiveness, violent behavior and suicide. These swings in mood are often referred to as "roid rage."

Although somewhat controversial, a theory has been established which suggests that anabolic steroids are addictive. This potential for addiction helped lead to a recent reclassification of anabolic steroids as controlled substances in the United States. Other adverse reactions to anabolic steroids include premature epiphyseal closure of long bones in adolescents resulting in short stature, acne, connective tissue abnormalities and AIDS from needle sharing.

Caffeine. One of the most widely available and used drugs in the world, caffeine is also used by athletes as an ergogenic aid.

The drug stimulates the CNS, which may increase alertness and reduce the perception of fatigue. In addition, caffeine has the ability to increase circulating levels of free fatty acids which can serve as a fuel source during physical activity. This alternate fuel source reduces the body's dependence on muscle glycogen. The potential for improved endurance has been demonstrated at doses of 250 to 400mg taken one hour prior to exercise and again immediately before exercise.

For this reason, caffeine is banned as an ergogenic substance by both the IOC and NCAA. Normal ingestion of caffeine in the form of coffee, tea or soft drinks will not produce a urine specimen which exceeds limits set by the IOC or NCAA. To get the doses required to improve endurance, an athlete would have to consume so much liquid that the resultant fluid load would be counterproductive. For this reason, caffeine suppositories are the dosage form of choice among endurance athletes.

Cocaine. The use of cocaine by athletes has received much media attention. However, there is little evidence suggesting that the drug possesses any ergogenic properties. Cocaine does not increase muscular strength, but other performance effects remain unknown. Still, athletes have taken the drug as an ergogenic aid. The effect on performance is most likely perceived, rather than real.

The toxicity of cocaine is well known. A number of athlete's deaths have been attributed to use of cocaine. A hypothesis has suggested that highly conditioned athletes may be at an increased risk for cocaine-induced mortality. Due to the muscle composition of these athletes, a dose of cocaine large enough to produce a seizure could also generate enough heat and lactic acid to result in cardiac shutdown.

Erythropoietin. As previously mentioned, blood doping is a method used by athletes to improve endurance. Human recombinant erythropoietin has the potential to produce an increase in red cell mass similar to, or greater than, that seen with blood doping.

Unpublished research conducted in Europe claims increases in hemoglobin and hematocrit, which resulted in improvements in athletic performance.

Erythrocythemia produced by the use of erythropoietin can lead to hypertension, congestive heart failure and stroke. The drug has been banned by both the IOC and NCAA, but a method for detection has not yet been developed.

Human growth hormone.

Continued on page 41

Questions on "How Widespread Is the Use of Drugs in Athletics?," published February 17, 1992 (Lesson 679-401-92-002) are worth two hours of credit. Credit eligibility expires three years after publication.

ANSWER SECTION

1. _____	5. _____	9. _____	13. _____	17. _____
2. _____	6. _____	10. _____	14. _____	18. _____
3. _____	7. _____	11. _____	15. _____	19. _____
4. _____	8. _____	12. _____	16. _____	20. _____

A. Overall program evaluation: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

B. Comments: _____
(attach sheet for more room)

C. Suggestions for future topics: _____

Continued from page 40

When naturally released from the pituitary gland, endogenous growth hormone results in growth and development of virtually every body system, including skeletal and muscle mass. Exercise and stress can stimulate growth hormone secretion. Growth hormone can be stimulated by other substances such as propranolol, vasopressin, clonidine, levodopa and several amino acids. Athletes are known to consume these drugs with the sole intention of increasing their growth hormone production.

Synthetic growth hormone is available and has also been used by athletes. Whether endogenous growth hormone is ergogenic is not known. Animal studies have proven the drug's effectiveness in improving size and strength of atrophied muscles, but have shown no effect on normal muscles.

Marijuana. The effects produced by the use of marijuana would most likely impair most athletic performances. Chronic use of the drug may lead to *antimotivational syndrome*, characterized by apathy, impaired judgement and loss of ambition.

Anecdotal reports by athletes have revealed limited use of the drug to produce relaxation prior to competition.

Narcotic analgesics. Although not considered ergogenic drugs, narcotic analgesics have a potential for misuse in athletics. These drugs have been used to treat an injury, which allows an athlete to participate while risking further injury. For this reason, the IOC has banned narcotic analgesics, but allows the use of aspirin and nonsteroidal agents for the treatment of less serious pain. The NCAA does not ban the use of narcotic analgesics. Heroin, however, is banned by the NCAA and some other sports organizations under the classification of a "street drug."

Tobacco. The use of tobacco products in athletics primarily involves the use of smokeless tobacco. Smokeless tobacco comes in two forms—snuff and chewing tobacco. Snuff is a finely shredded product which is placed between the lower lip or cheek and gums. Chewing tobacco is more coarse and is placed in the cheek pouch. Smokeless tobacco seems to be a popular ritual associated with baseball. Surveys of minor league players have shown that nearly 40 percent of players use smokeless tobacco products. When examined, the players who do had higher rates of leukoplakia and other periodontal disease than those not using these products.

Nicotine, the active ingredient, is used by athletes for a number of reasons, some of which are contradictory. Stimulatory and calming effects, appetite control and uses unrelated to performance are most frequently mentioned. Nicotine has not been shown to improve reaction time or aerobic power. Following a dose of nicotine, the swimming mechanics of rats was improved, but endurance was decreased. This may be due to nicotine's negative effect on oxygen consumption.

No athletic organizations ban the use of tobacco.

Miscellaneous drugs

A number of other drugs may be used by athletes as ergogenic aids. The complete list of substances is beyond the scope of this review. However, a few of these drugs are used by such a large number of athletes, or are commonly used for specific sports that they warrant mentioning.

Beta-blocking agents adversely affect physiologic performance as measured by endurance and oxygen consumption. Furthermore, the drugs appear to have no affect on muscular strength. These drugs can, however, reduce tremor and improve hand and arm steadiness. This can dramatically aid athletes in precision shooting events. Beta-blockers are banned in shooting events by the IOC and NCAA.

Diuretics have already been discussed as a means of avoiding detection by urine drug tests, but these drugs are also used by athletes participating in weight-specific events. Boxers and wrestlers looking for a rapid weight loss may contemplate the use of diuretics.

Phenylpropanolamine and **ephedrine** are nonprescription drugs which are structurally related to amphetamines. Despite this similarity, these drugs don't possess any ergogenic benefit. The potential for misuse by athletes is more likely related to the easy availability rather than effects on performance. Sympathomimetic amines are considered to be banned substances by the IOC and NCAA.

Albuterol, a selective beta^2 adrenergic agonist, has been shown to improve pulmonary function in elite athletes who are not asthmatics. When given by inhalation, the drug increases time until exhaustion. Currently, beta agonists can be used in IOC and NCAA competition, if prescribed by a physician for a medical condition.

A plethora of nutritional products exist on the market today, many with the claim of improved health or performance. Vitamin and mineral supplementation is very common among athletes. However, in controlled trials, these supplements have never been shown to produce measurable increases in athletic performance.

Chromium is one mineral supplement that is being heavily promoted to athletes as a safe alternative to anabolic steroids. The proposed mechanism of action is an increase in the uptake of amino acids by muscle cells. These claims are based on several studies where many other variables such as diet and other ergogenic drug use were not controlled. Although chromium appears to be nontoxic, the use of the product may signal an athlete at risk for progression to more potent ergogenic drug use, such as anabolic steroids.

Protein supplements. A common belief among athletes wishing to gain muscle mass is that large doses of protein are essential. Dietary protein is often supplemented with protein powders and individual amino acids. This protein load has not been shown to speed muscle gain, and is probably excessive. The additional protein is converted to fat, a metabolic step which requires water. This can result in dehydration, which, for a competing athlete can be more detrimental than being outweighed by an opponent.

Drug use control

Both amateur and professional organizations have designed drug use control programs based on urine testing. While the IOC supports competitive fairness as the primary reason for conducting drug use testing, the NCAA is concerned with the health and welfare of the athletes as well. In contrast, professional athletics is more concerned with protecting public image. Some major problems exist with the current format of drug use control.

- Detection is easy to avoid since testing is conducted at specific events.
- Only a minority of athletes are actually tested.
- Even though less than effective, these programs are very expensive.

Opportunities for Rx'ers

These programs have had limited success because they only focus on detection and enforcement. A complete program should also address drug distribution, education and research. As drug use control experts, pharmacists can play a valuable role in meeting these deficiencies.

Conclusion

An essential goal of athletics is the pursuit of physical excellence. This is embodied in the Olympic motto of "higher, faster, stronger." Unfortunately, athletics is also becoming a contest in pharmacology. The use of drugs in athletics is relatively commonplace in a variety of sports at virtually all levels of competition.

The substances use by athletes include both ergogenic and social drugs. Sound scientific studies on the performance-enhancing properties of drugs are few in number. Future research into ergogenic properties may be difficult, due to ethical considerations. Even if such studies could be performed and the conclusions were that drugs do *not* improve athletic performance, athletes may still use drugs based on anecdotal evidence.

To discourage drug use in athletics, drug control programs are important, but these programs must involve more than just drug testing. Those involved in athletics should be educated about the health risks associated with drug abuse. Pharmacists are uniquely qualified to assist in a variety of drug use control efforts.

For bibliography information, please contact the editor.

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The newspaper of drug store retailing

March 2, 1992

DRUG STORE NEWS

Vol. 14 No. 5

A Lebhar-Friedman publication

Osco finetunes its downsized prototype

American Drug Stores is expanding a downsized store prototype developed for its Osco division and first introduced last fall. The new format is smaller and more tightly focused on core drug categories in line with the continuing shift in U.S. chain drug retailing away from general merchandise categories.

SALT LAKE CITY — American Drug Stores is set to roll with a new, smaller store format for Osco Drugs that puts greater emphasis on pharmacy and core drug store merchandise.

At 14,000 to 15,000 square feet, the new format is significantly smaller than Osco's standard footprint of 20,000 square feet and up. It cuts down on promotional and general merchandise in favor of a tighter mix of drug store basics, particularly in HBA items anchored by a prominent pharmacy department.

Osco's new look debuted last fall in Kansas City with a single new store. Since then, the new prototype has been opened in four locations in Phoenix. Dubbed American's "New Vision" drug store by its proponents, it will serve as the basis for the chain's new-store expansion in the 1990s, said Cal Drexel, head of investor relations for parent company American Stores. It may also influence the future direction

See **American** *page 25*

Revco bid stands alone after Eckerd pulls out

Eckerd has pulled out of the bidding for Revco D.S., deeming the costs and delays of the effort too high to continue. The surprise withdrawal could signal clear sailing ahead in Revco's struggle to emerge from bankruptcy as an independent company.

By James Frederick

CLEARWATER, Fla. — In the latest and perhaps final surprise twist in the protracted struggle for control of Revco D.S., Jack Eckerd Corp. has withdrawn its bid for the bankrupt chain. Eckerd's unexpected decision to table its year-long effort to acquire the chain leaves the field open for Revco to emerge from Chapter 11 under its own plan of reorganization—perhaps as early as this spring.

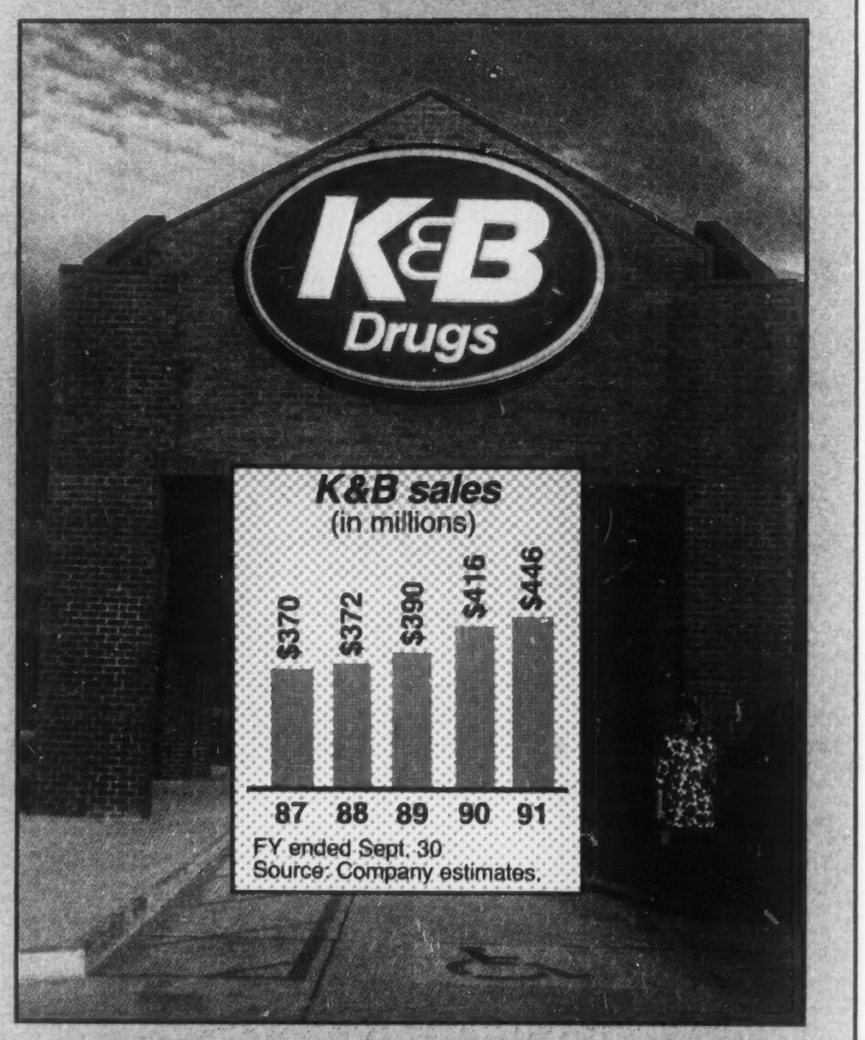
That effort gained momentum Feb. 14 with the approval in U.S. Bankruptcy Court of Revco's reorganization plan and disclosure statement, and its release to creditors for a vote. The voting deadline is March 6, with a court confirmation hearing on Revco's plan set for March 11.

The two drug chains jointly announced in mid-February that Eckerd "will postpone indefinitely consideration of its plan of reorganization for Revco" to "permit an amended Revco plan to proceed with confirmation in the Bankruptcy Court without incurring significant additional expense and delay."

The move could hasten the end of Revco's three-and-a-half-year bankruptcy ordeal, which has consumed the attention of company managers and more than $60 million in legal fees.

See **Revco** *page 25*

K&B positions for growth with prototype debut



K&B sets its prototype for the '90s.
See coverage of new store format page 3.

LATE NEWS

•BENTONVILLE, Ark. — Wal-Mart will add another 160 discount stores, many with pharmacies, in the fiscal year that began Feb. 1. The expansion will push the chain's logo into three new western states—Idaho, Montana and Oregon—and boost store total to roughly 1,880 units nationwide.

•PONTIAC, Mich. — Perry Drug Stores has acquired the Wonder Drug Store in Clarkston, Mich., adding a third unit in that market. The 5,000-square-foot site will be doubled in size and converted in the near future—giving Perry 208 drug stores in the state.

•GREENVILLE, S.C. — Revco D.S. has picked this stronghold market as the site of its next Health and Beauty Expo April 24-25.

FEATURES

Beverages chug along with sales

Bargain-hunting and health-conscious consumers push beverage sales in products ranging from soda to fruit drinks to beer. **Page 9.**

New products set pace in hair, skin

How much skin and hair sales are drug stores grabbing? What are the hot products? *DrSN's* exclusive study tells all. **Page 13.**

NACDS small chain executives swapped strategies and ideas at the NACDS Conference in New Orleans. See full coverage page 6.

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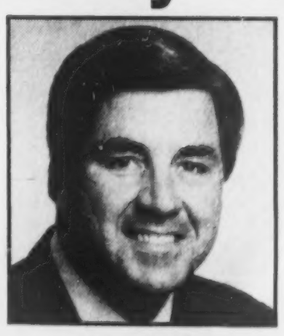
SECOND CLASS

Yingling sees '92 Thrifty recovery

By rolling back mistakes of recent years and with new focus on the neighborhood consumer, Thrifty chairman and ceo William Yingling predicts turnaround by fourth quarter 1992 and the chain's eventual sale by parent Pacific Enterprises.

By Allene Symons

LOS ANGELES — "Our focus—the absolute imperative—is on turning around the company," Thrifty Corp. chairman and ceo William Yingling told *Drug Store News* in the wake of disclosure by parent Pacific Enterprises that it will sell five retail units but retain the Thrifty Drug chain for now.



Yingling

"Everyone understands that Thrifty is not for sale presently," said Yingling, "but Pacific Enterprises has stated its intention to focus on the utility business," which indicates the eventual sale of Thrifty Drug. When asked whether this might trigger a management-led buyout, Yingling responded: "I wouldn't rule anything out."

In a mid-February meeting with 400 suppliers, Yingling detailed plans to refocus the drug store chain. "We talked about change from a unified footprint to one that allows for flexibility in the way we market, changes in the

See **Thrifty** *page 25*

NEWS IN BRIEF

Philips, Phar-Mor file suit, counterclaim

SOMERSET, N.J.—Philips Lighting Company has filed suit against Phar-Mor, charging that the chain wrongfully terminated and breached a product supply and promotion agreement. The manufacturer is seeking monetary damages for unpaid goods and the return of promotional allowances which it paid to Phar-Mor.

Phar-Mor, in a statement, said the complaint was "totally without merit," adding that the contract was canceled and replaced by one with General Electric because "Philips was constantly out-of-stock and unable to fulfill its supply obligation."

Steven Goldmacher, director of public relations for Philips, said since the matter was in litigation, Philips believed that any discussion of the suit would be inappropriate.

Phar-Mor has filed a counterclaim against Philips for damages the company claims it suffered as a result of Philips' breach of contract.

Chains take shine to Little Silver

LITTLE SILVER, N.J. — The successful opening of a 9,500-square-foot CVS here in late January may soon be marred by the possibility of Walgreens moving to an adjacent site.

"On the first day of business, the district manager told me he'd never seen such a hot opening," said Ben Lucarelli of Northshore Properties, the commercial real estate brokers who rent to CVS. Lucarelli said he expects the new site to generate sales of $5 million a year. The A&P across the street, he said, has sales of $15 million a year.

The new wrinkle is that Walgreens has expressed interest in a 14,000-square-foot site in an adjacent property.

Pharmasave shifts territorial heads

LANGLEY, BRITISH COLUMBIA — There's been a shift in management at Pharmasave Drugs Ltd. Don Kyte, regional general manager of Pharmasave Atlantic for the past four years, has decided to purchase a Pharmasave location in Dartmouth, Nova Scotia.

Tom Smith, formerly regional general manager of Pharmasave Central in Manitoba, will replace Kyte as the manager of the 42-store region.

David Oberding will take over Smith's territory as regional general manager of Pharmasave Central, which includes Manitoba, Saskatchewan and the northwestern area of Ontario. He will also be responsible for coordinating various Pharmasave marketing programs.

Oberding was formerly district manager of MacLeod/Stedman, a concern which worked with independent retailers to enhance sales and profitability.

Pharmacy relief for Calif. flood victims

LOS ANGELES — The Pacific storm that pounded Southern California, leaving behind six dead and flood damage in multi-millions of dollars, brought out the good samaritan in drug stores near one of the hardest hit communities.

North of Los Angeles, in Ventura, where an entire mobile home community was devastated, Thrifty Drug rallied to help its pharmacy patients, most of whom lost their homes and sought refuge in emergency shelters.

"The trailer park is a half mile away," said pharmacist Richard Ando. "At least 10 of our patients lived there, so the company has authorized us to give them free medication for the next couple of weeks." Rogers Pharmacy in Ventura also offered its patients replacement of their medications at no charge, said pharmacist Jim Leftwich.

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Cut costs, manufacturers told at NACDS Distribution

By Barbara White

ORLANDO — The message to suppliers rang clear at the NACDS Distribution/Logistics Conference, held here recently: manufacturers helping retailers slash costs will build their business. Vendors whose programs and service records lag behind will find themselves in a so-called second tier of providers.

"Wal-Mart has made demands as to what they are looking for from manufacturers," said Curtis Neel Jr., vp of distribution for Jack Eckerd Corporation. "They parted the waters so that we have an easier time making those demands."

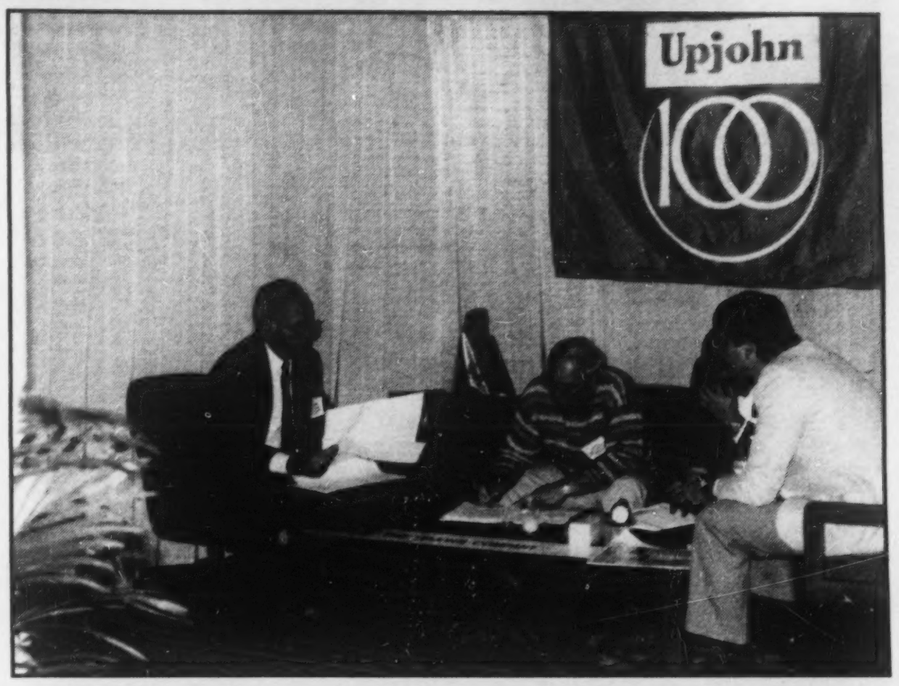
Said Joseph Martha, an Andersen Consulting partner, who spoke at the third annual conference: "Retailers are getting tougher on suppliers. Their margins are too tight; sales help is expensive. They're counting on suppliers to reduce costs in other areas."

Some manufacturers are already aggressive in forging alliances. "Procter & Gamble and Kimberly-Clark spend a lot of time thinking about ways to improve service. They come to us with ideas," said Gerald Cox, vp of the distribution center at Thrift Drug.

On-time orders

Cox said that since Thrift isn't yet using EDI, the chain is FAXing orders to P&G to speed up the delivery cycle. That change was suggested by the manufacturer as a way to fill in technology gaps.

Chains' individual needs may differ, but the big issues are similar industry-wide. Dependable shipments that are on time and have short, consistent cycles can reduce their inventory costs. Reliable information, including EDI links, can also add to savings through better management of assets.



At Upjohn booth (l to r): Frank Gable, vp-sales, Harco; Jack Marcacci, director-southeast region, and James Tesser, logistics service manager, both of Upjohn; and Terry Weber, distribution director, Harco.

"Information can help us to control inventory better," said John Brown, senior vp of Walgreens. "When we know where everything stands in the distribution pipeline, we can do a better job scheduling merchandise [entering] the store."

Retailers want manufacturers to aim for orders that are so reliable, they don't need to be verified on receipt—a move they say will reduce receiving costs by 50 percent.

"It's cumbersome to check in merchandise," said Cox. "We want manufacturers to do a better job on their end so that we can just scan the boxes instead of counting pieces."

Ron Peterson, executive vp-marketing and merchandising, Jack Eckerd Corp., said manufacturers must customize programs.

The ability to do so requires a high level of trust between retailer and manufacturer and a good track record.

"Our first concern is that orders are on time and are complete, so we're working with our customers to find ways to make that happen consistently," said a P&G spokesperson. "We're also very concerned about damage, so we're trying to identify where it's occuring in the system and are beginning to plan around that."

Eveready and Johnson & Johnson are just two examples of vendors with a mission to reduce distribution costs. "We have made some drastic changes in our systems and management so that we can better serve our customers," said Dick Pocek, director of logistics at Eveready Battery Company, Inc.

At Johnson & Johnson, the quest is for the perfect order, according to Robert Edwards, director of logistics at Johnson & Johnson Consumer Products. "When time and quantity problems no longer need to be solved, we can enter the next level of working with retailers to help them sell the product," said Edwards.

Brooks bids Jennings adieu as he enters food market

Nearly 100 people attended John Jennings' (left) farewell party from Brooks Drug, Inc. held at a country club in Lincoln, R.I. on January 3. Jennings, who was with Brooks since 1986, left to become president of Volume Inc., a Sharon, Mass.-based food diverter. Brooks' David Morocco (right), replaced Jennings as vp-marketing.